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Medical paradigms and Primary Health Care: surveillance of the population and/or production of life?*

Over the past few decades there has been an important debate in Brazil about health care alternatives to the dominance of Hospital Medicine. Discussion around theoretical propositions such as 'Health Surveillance', 'Health Promotion', 'Programmatic Actions', the 'Project of Life Defense', 'Amplified Clinics' the 'Micropolitics of Care', 'Peripatetic Clinics', 'Harm Reduction' and others[1-3] have informed this debate, but perhaps one of the key question can be distilled into the nature and future role of the General Practitioner. The history and place of Hospital Medicine is well-established in the Brazilian Public Health System (SUS) but how does primary health care with its different experts, discourses, technologies and practices integrate with the hospital system to create a universal and comprehensive 'Web of Health Care'? Are there lessons to be learned from other countries about how to manage this problem of integration?

Some Anglo-Saxon countries with universal health care systems, such as the UK, have addressed this problem through providing and supporting a strong primary care sector. However, simply transferring these organizational arrangements to Brazil is unlikely to succeed as there is a very different history and cultural tradition. Yet a number of authors[4-7], influenced by post-structuralist thought, have argued that these new forms of health care integration that can be seen in other countries are underpinned by important shifts in the very nature of medical knowledge and clinical practice. Understanding these changes may show the possibilities and limits of health care reform in Brazil.

The starting point for many of these analyses is Foucault's *Birth of the Clinic*[8] in which he described the origins of the system of modern medicine that for more than two centuries is by the sort of clinical activity that occurs in hospitals. In the late 18th century Hospital Medicine emerged as a consequence of the key idea that disease could be localised to an intra-corporal pathological lesion. Previously, disease had roamed through the body and between the body and its environment; these was no specific point at which the disease 'stopped', where it could be captured or treated. The idea of a localized pathological lesion, however, meant that it became possible to carry out a clinical examination of the patient's body to identify the lesion (as well as a post-mortem to confirm that diagnosis). And what better place to conduct this examination than the 'neutral' space of the hospital, unencumbered by all the distractions of the patient's 'natural' home. This framework for understanding the nature of disease/illness has dominated health care provision for over two centuries but that does not mean it will continue for centuries to come. As Foucault[8] (p. 3) noted: "this order of the solid, visible body is only one way - in all likelihood neither the first, nor the most fundamental - in which one spatialises disease. There have been, and will be, other distributions of illness".

Medical prospects in the twentieth century: the emergence of Surveillance and Community Medicine (SCM)

During the 19th century Hospital Medicine came to dominate health care provision in Western countries and during most of the 20th century that dominance spread into a world-wide phenomenon. For most citizens of the modern world the term 'health care' conjures up an image of a hospital together with its clinics and beds. It is not therefore unsurprising that alternatives to the hospital have struggled for recognition and resources. Even so, there are

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indications that important changes began to occur across clinical medicine in the middle of the 20th century that implied a new way of thinking about health and illness. These changes, in their turn, indicate that alternatives to the hospital can begin to emerge across the health care landscape.

A new type of medicine began to emerge at the very beginning of the 20th century in certain Western countries. Responding initially to the problem of managing the new 'social' diseases - such as tuberculosis, venereal diseases and childhood infections – medicine began to treat the population rather than the individual patient's body as the object of intervention. Tuberculosis or venereal disease, for example, required some sort of community surveillance programme to track their spread. In effect, medicine began to devote new attention to the interactions between people in the community:

> This multifaceted population space encompasses the physical gap between bodies that needs constant monitoring to guard against transmission of contagious diseases […] This new Surveillance Medicine involves a fundamental remapping of the spaces of illness. This includes the problematization of normality, the redrawing of the relationship between symptom, sign and illness, and the localization of illness outside the corporal space of the body [….] each illness is simply a nodal point in a network of health status monitoring.[5] (p. 393, 400, 401)

In this new conceptualization, pathology was not an essentially static phenomenon to be localized to a specific point, but was seen to travel throughout the social body, appearing only intermittently. A new form of medicine was required that would survey this 'normal' population. The identification of 'risk factors' in the second half of the century consolidated this analysis. Everyone had risk factors; everyone was at risk. Was anyone, therefore, truly healthy? Or, was everyone now in a precarious pre-illness state? The solution was to widen the surveillance role of medicine to embrace 'normal' populations and 'healthy' people. Patients who seemed healthy might have incipient disease that could be identified through screening; populations that seemed normal could be provided with health promotion that advised on healthy behaviours; patients consulting with health care could have their risk profile checked. Not only were new forms of health care provision devised but new health problems emerged. The neuroses (anxiety, depression, etc.), for example, that potentially affected everyone, replaced insanity (the affliction of the few) as the main problem of mental health and chronic illness was 'discovered' to be everywhere during the 20th century. Both 'inventions' justified increased surveillance and further vigilance[4,5,9].

The hospital had emerged at the point when illness was localised to a pathological lesion inside the body. The hospital separated those with illness/disease (who had a pathological lesion) from those who were healthy (without a pathological lesion). Successful treatment meant discharge from hospital to re-join the healthy outside its walls. The central place of the hospital in health care provision was therefore based on the binary separation of disease from non-disease, of hospitalisation from non-hospitalisation. Other forms of health care provision supported this binary divide as the hospital depended on peripheral health care workers (such as general practitioners) to make the preliminary identification of pathology and arrange for admission to a hospital bed. Inevitably, therefore, non-hospital alternative health care was subservient to the hospital; indeed, it almost owed its very existence to the hospital 'system' and the pathological forms of disease that underpinned it[10].

But if 'illness' is no longer just located in the pathological lesion, if it is to be found in risk factors, in the population, in supposedly healthy people, then the prime justification of Hospital Medicine – and the health care system that underpins it – begins to lose it ascendancy. That is the moment when the debate about 'alternatives' becomes possible. Primary Care, first identified and labelled as such in the 1960s, is one product of these changes in the nature of medical knowledge and clinical practice. The Brazilian Collective Health movement and, on it, the debates about clinical practice and the management of the health care after the 1980's, seems to us that are partially a product of those paradigmatic forces that began to impact on both the practice and organisation of medicine about half a century ago in countries like the UK. They have as a common ground an emphasis on the biographical elements in the patient's problem that represent a significant break from the old clinic-pathological hospital medicine[10].

Problematizations

When Foucault described the emergence of hospital medicine in the late 18th century he also claimed that this new form of clinical practice mirrored other innovations in the surveillance of individual bodies (such as in the prison, the school and the workshop)[11]. In fact, he argued that close analysis of the body taking place in activities such as the clinical examination and the post-mortem provided a mechanism for constructing those very bodies. In other words, the perception of an anatomical body of cells, tissues and organs that is so familiar today has its origins in the routine practices of a form of clinical medicine that were introduced two centuries ago.

The advent of Surveillance and Community Medicine, however, also has effects beyond its immediate practical intent. While the overt logic is the identification of illness, present and future, and its prevention and amelioration, the constant surveillance of the normal population and the demand that everyone should continuously be on their guard against hidden risks establishes a new identity. Guarding against risks, mostly unseen and often unknown, requires a self-vigilance and that state of constant awareness might be described as reflexivity.

In other words, the practice of Surveillance and Community Medicine constructs an identity just assuredly as the clinical examination two centuries ago began the materialization of the individual anatomical body. Promotion of the new forms of health care delivery in their struggle with the old Hospital Medicine is more than a battle over how healthcare should be delivered. In the last instance what is at stake here are ways and possibilities of existence of individuals and collectives.

The above arguments reinforce the important idea that medicine does not have an 'ontological essence' (it doesn't exist by itself), neither an epistemological one (there is no single medical model). Medicine doesn't have a 'political essence' (the effects of medical action are not necessarily the exercise of discipline and control social) and a patriarchal one (medicine and doctors do not intend simply to exercise control over women and their bodies)[7]. Medicine, Foucault taught us, is a social practice that answer to different and complex power relations on the micro and macro levels of society; the effects of its discourses and practices are always an open field of dispute.

This critical attitude can be helpful in improving the contributions of medical perspectives to a politics of life that look for a change in the *status quo*. To have a critical position, for example, to the biopsychosocial approach to illness - that

is a central aspect of the hegemonic 'Community and Family Medicine' project in Brazil nowadays – that have been offered 'new model' or as a panacea to reconstruct the world of illness despite its severe limitations[12]. We think also that we might, in some situations, be more aware (and critical) of the use of the concept and strategy of 'risk'. This is not a neutral and 'scientific' concept but a historical one that, in many situations, dissolves the borders between healthy and unhealthy across the health field placing everyone in a web of observation where the experts fabricate norms of classification and have a great influence on what we affirm as health problems today[13,14].

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